

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02698

Reg. Dist. No.

182

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Priscilla Lowwood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 28, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13, 1946

to

March 28, 1946

and that I last saw him alive on

March 28, 1946

Immediate cause of death

Cardio-renal failure

DURATION

Due to

Chronic myocarditis -

Due to

Chronic tachycardia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

1945

1873

✓

RECEIVED

APR 2 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Harford
 City or town Edgewood Arsenal, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Station Hospital, Edgewood Arsenal, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1625 North Spring St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN H. CONNOR

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married Widowed

6.(b) Name of husband or wife

Elizabeth Popp

8.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

29 September 1884

8. AGE:

Years

Months

Days

If less than one day

61528

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Engineer, U. S. Government

11. Industry or business

Service Division, U. S. Gov't.

FATHER

12. Name

John Henry O'Connor

13. Birthplace

Unknown

MOTHER

14. Maiden name

Elizabeth Pifer

15. Birthplace

Unknown

16. Informant

Mrs. Annie Shea

Address

1641 Harford Ave., Baltimore, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 30th, 1946
(month) (day) (year)

Cemetery or crematory

Baltimore

Location

E. North Avenue

18. Funeral director

George J. Ruth, Inc.

Address

1735 Harford Avenue

19.

(Date rec'd by registrar)

19

46Ann Sheehan
adh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 March 19 46 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

did not attend 19 46 to 19 46and that I last saw him alive on not seen 19 46

Immediate cause of death:

Coronary Thrombosis

DURATION

Due to generalized arteriosclerosis

Due to

Other conditions cirrhosis of the liver.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James V. Daininger 1st Lt. M.C.

M. D. or other

Address

Edgewood Arsenal, Md.Date signed 3-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

02701

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH: *Harford*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? *7 hrs.*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Maryland* County.....*Harford*
City or town.....*Abertown*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....*Bush Chapel*
(If rural, give LOCATION)
2.(a) If veteran, name war.....*none*

3. (a) FULL NAME

Maggie Cullum

3. (b) Social Security Number

none

4. Sex.....*Female* 5. Color of race.....*White* 6. (a) Single, married, widowed, or divorced.....*Widowed*
6. (b) Name of husband or wife.....*Robert L. Cullum*
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....*November 15, 1859*
8. AGE: Years.....*86* Months.....*4* Days..... If less than one day..... hrs. min.

9. Birthplace.....*Germany*
(Town, county, and state)
10. Usual occupation.....*None*

11. Industry or business
FATHER 12. Name.....*Vincent Flower*
13. Birthplace.....*Germany*
MOTHER 14. Maiden name.....*Maggie Flower*
15. Birthplace.....*Germany*

16. Informant.....*Robert L. Cullum*
Address.....*Abertown, Md. P.O. #1*
17. Burial, cremation, or removal, Which?.....*Burial* Date thereof.....*March 23, 1946*
(month) (day) (year)
Cemetery or crematory.....*Bush Chapel*
Location.....*Near Abertown*

18. Funeral director.....*Henry Tarrington Sons*
Address.....*Abertown, Md.*
19. *Mar. 22* 19 *46* *G. L. Lewis M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 21* 19 *46* at *5:25 A.* M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *March 20* 19 *46* to *March 21* 19 *46*
and that I last saw her alive on *March 21* 19 *46*

Immediate cause of death.....*Cerebral Menorrhage*
Due to.....*Arteriosclerosis*
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE.....*Frank Webster M.D.*
Address.....*Harford* Date signed.....*3/21/46*

10530

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

Handwritten signature

ART 35 AM

SAG CO

RECEIVED
MAR 25 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02702/81

1. PLACE OF DEATH:

County.....*Harford*
 City or town.....*Aberteen Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*6 yrs.*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Charles*
 City or town.....*Bel Elton*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....*None*

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*Colored* 6. (a) Single, married, widowed, or divorced.....*Married*
 6. (b) Name of husband or wife.....*Joseph G. Curtis*
 7. Birth date of deceased (mo., day, yr.).....*March 9 - 1883*
 6. (c) If alive, give age.....*66* years
 8. AGE: Years.....*63* Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....*Bel Elton Charles Co Md.*
(Town, county, and state)10. Usual occupation.....*Houseworker*

11. Industry or business.....

12. Name.....*Nellie Barney*13. Birthplace.....*Virginia*14. Maiden name.....*Nellie Thomas*15. Birthplace.....*Charles Co Md.*16. Informant.....*Mr. Joseph G. Curtis*Address.....*Aberteen Md.*17. *Burial* Date thereof.....*March 13 - 1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....*St. Thomas*Location.....*Bel Elton Md.*18. Funeral director.....*Henry T. Young Sons*Address.....*Aberteen Md.*19. *Mar. 12* 19 *46* *Nellie Z. Riley*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 9* 19 *46* at *6:25 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....*head on arrival*.....19.....

Immediate cause of death.....

*Bariumium & uterus with
generalized metastasis*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Thos. P. Thompson* M. D. or other.....Address.....*Aberteen Md.* Date signed.....*Mar. 11/46*

RECEIVED
APR 2 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472 +

CERTIFICATE OF DEATH

02703

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harvick Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yr
 Hospital, institution, or street address where death occurred:
617 Bourbon St.
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Harvick Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 617 Bourbon St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

William Stephens Daugherty

3. (b) Social Security Number

?

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 27 19 46 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 45, to Mar. 27 19 46
 and that I last saw him alive on Mar. 26 19 46

Immediate cause of death

Carcinoma of left lung

DURATION

8. AGE:

Years

Months

Days

If less than one day

65018- hrs. - min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

Steam Fitter

11. Industry or business

Wm. S. Daugherty

FATHER

12. Name

Wm. S. Daugherty

13. Birthplace

Md.

MOTHER

14. Maiden name

Georgeanna Cantler

15. Birthplace

Md.

16. Informant

Mrs. Bessie E. Daugherty

Address

617 Bourbon St. Harvick Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Mar. 30, 1946

(month) (day) (year)

Cemetery or crematory

Southern Cem.

Location

Dublin Harford Co. Md.

18. Funeral director

H. W. Madison Mitchell

Address

Harvick Grace Md.

19.

Mar. 28 19 46G. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

22. SIGNATURE

G. L. Lewis M.D. or otherAddress Harvick Grace, Md. Date signed 3-28-46

RECEIVED
APR 1 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 02764 182

1. PLACE OF DEATH:

County..... Harford
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... MD County..... Harford
 City or town..... Creswell Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name War.....

3. (a) FULL NAME

David Emory Ely

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Annie A. Ely
 6.(c) If alive, give age..... 78 years
 7. Birth date of deceased (mo., day, yr.)..... June 22 - 1867

8. AGE: Years..... 78 Months..... 10 Days..... 22 If less than one day..... hrs. min.
1867 June 22

9. Birthplace..... Harford Co Maryland
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... John Ely
 13. Birthplace..... Maryland
 14. Maiden name..... Hannah Tucker
 15. Birthplace..... Maryland

16. Informant..... (The Family) Mrs. Annie A. Ely
 Address..... Bel Air Md

17. Burial Date thereof..... Mar 5/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... mt zion
 Location..... Fountain Green

18. Funeral director..... Deen & Porter
 Address..... Bel Air Md

19. March 4 19 46 Phicilla Lowwood
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 2 19 46 at 2:45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11-2 19 38, to 3-2 19 46

and that I last saw him alive on 3-2 19 46

Immediate cause of death..... Coronary occlusion
 DURATION..... 2-26-46

Due to..... Chronic glomerular nephritis
with hypertension Years.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Thos O Hodons MD
 M.D. or other

Address..... Edgewood, Md Date signed..... 3-3-46

RECEIVED

MAR 8 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02705 180

1. PLACE OF DEATH:

County Hartford
 City or town Edgewood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Hartford
 City or town Edgewood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lillian M. Evans

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife George N. Evans 5. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb 2 1866
 8. AGE: Years 80 Months 1 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name George Mable
 13. Birthplace Maryland
 14. Maiden name Mary Brown
 15. Birthplace Maryland

16. Informant George N. Evans
 Address Edgewood Maryland

17. Buried Date thereof Mar 25 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John
 Location Abingdon Maryland

18. Funeral director Howard K. McCrossen
 Address Abingdon Maryland

19. Mar 20 1946 Marie M. Moulton
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941 to March 1946
 and that I last saw her alive on March 22 1946

Immediate cause of death

Acute pulmonary edema 4 hrs

Due to Anticoagulant C.D. Disease 3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Paul H. Horkley M. D. or other

Address Churchville Md Date signed March 24

RECEIVED

MAR 28 1945

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 02796 184

1. PLACE OF DEATH:

County Harford
 City or town Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford
 City or town Forest Hill Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION) no

2.(a) If veteran, name war _____

3. (a) FULL NAME

Geo. Fickus

3. (b) Social Security Number

no

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna Fickus

alive 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 26 1878

8. AGE: Years 67 Months 4 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation Farmer11. Industry or business Dairy Farm12. Name Henry Fickus13. Birthplace Germany14. Maiden name Unknown

15. Birthplace _____

16. Informant Mrs. Anna FickusAddress Street, Md. Rural

Burial Date thereof March 19, 1946
 (Burial, cremation, or other disposal) (month) (day) (year)

Cemetery or crematorium Ascension Cem.Location Harford Co Md.18. Funeral director H. S. BaileyAddress Darlington Md.

March 18, 1946 M. W. Kirk
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1946 to Mar 16 1946
 and that I last saw him alive on Mar 15 1946

Immediate cause of death Pneumonia 2 days
 DURATION

Due to ✓Due to ✓Other conditions Chronic Nephritis 3710

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. P. Snodgrass M. D. or other

Address Darlington Date signed 3/16/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 28 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1 232

CERTIFICATE OF DEATH

02707

Reg. Dist. No. 181

1. PLACE OF DEATH: Hagerford
 County Hagerford
 City or town Shedden
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
129 S. Rogers St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Hagerford
 City or town Shedden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 S. Rogers St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME J. William Godwin

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emma Irvin

7. Birth date of deceased (mo., day, yr.) Nov. 21st 1862 8. (c) If alive, give age 78 years

8. AGE: Years 83 Months 3 Days 3 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation R.P. Operator

11. Industry or business Telegraph - Rtd.

12. Name Benjamin Godwin

13. Birthplace Maryland

14. Maiden name Mary Jeffers

15. Birthplace Maryland

16. Informant Mrs. C. E. Brown

Address 129 S. Rogers St.

17. Burial, cremation, or removal, which? Burial Date thereof Mar. 4 1946
 (month) (day) (year)

Cemetery or crematory Bakers

Location Shedden Md.

18. Funeral director Henry Tarrington & Sons

Address Shedden Md.

19. Mar. 4 1946 Allie H. Riley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Male 2nd 1946 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 1st 1946 to March 2nd 1946
 and that I last saw him alive on March 2nd 1946

Immediate cause of death Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. P. Thompson M. D. or other

Address Shedden Md. Date signed Mar. 4 1946

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

SIGNATURE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

RECEIVED
MAR 15 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02708

Reg. Dist. No. 185

1. PLACE OF DEATH:

County.....Baltimore
 City or town.....Harford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....4 yrs. mo.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Harford
 City or town.....Harford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....no

3. (a) FULL NAME

Corbin Marion Grafton

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 22 - 1890

8.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

556

hrs.

min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Watchman

11. Industry or business

FATHER

12. Name.....William Charles M. Grafton

13. Birthplace

Harford Co. Md.

MOTHER

14. Maiden name.....Virginia Minnich

15. Birthplace

Baltimore Md.16. Informant.....Mrs. William Waring

Address

642 Adams St. Harford

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

April 3 - 1946
(month) (day) (year)

Cemetery or crematory

Deer Creek

Location

Chestnut Hill, Harford Co.

18. Funeral director

Henry T. J. J. Sons

Address

Chesapeake Md.

19. (Date rec'd by registrar)

19

46

A. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 31..... 1946..... at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 30..... 1946..... to March 31..... 1946
 and that I last saw him alive on March 31..... 1946

Immediate cause of death

Cerebral hemorrhage
Left hemisphere
arterio-sclerosis

Due to

arterio-sclerosis

Due to

Malig. Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John W. Welch M.D.

M. D. or other

Address

Harford Co. Md.

Date signed

April 1, 1946

RECEIVED
APR 4 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119-2

CERTIFICATE OF DEATH

02709

Reg. Dist. No. 184

1. PLACE OF DEATH:
County Harford
City or town Whiteford
(If outside city or town limit, write RURAL and give nearest town)
How long in above place of death? 1 1/2 yrs.
Hospital, institution, or street address where death occurred:
Back of Whiteford Canning House
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Whiteford
(If outside city or town limit, write RURAL and give nearest town)
Street No. Back of Whiteford Canning House
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
William Thomas Grafton

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) April 16 1944 B.(c) If alive, give age _____ years

8. AGE: Years 1 Months 10 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Del. Co., Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Hugh T. Thomas Grafton

13. Birthplace Delta Penn.

14. Maiden name Dorothy Louise Perkins

15. Birthplace Delta Penn.

16. Informant Hugh Grafton

Address Whiteford, Md.

17. Burial Date thereof Mar. 9-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Hope cemetery

Location Delta, P. O. P.

18. Funeral director Robert P. Perkins

Address Delta Penn.

19. March 7, 1946 M. H. Kierke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946 at 4:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
and that I last saw him _____ alive on _____ 19____

Immediate cause of death Strangled by resuscitated
Round worms
(ascaris trichuris)

Due to _____

Due to _____

Other conditions Disinfectant

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Enoch A. Hunt M.D.

Address Cardiff, Md. Date signed 3/6/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BUREAU V.S.

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

1. PLACE OF DEATH: Harford
County.....
City or town..... Rocks, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 yr.
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

2. (a) If newborn infants, give residence of mother)
State Maryland County Harford
City or town Rocks, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Clark Hall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married
B.(b) Name of husband or wife..... <u>Hattie P. Hall</u>		
	6.(c) If alive, give age <u>71</u> years
7. Birth date of deceased (mo., day, yr.) <u>October 1, 1871</u>		

8. AGE:	Years	Months	Days	If less than one day
	74	5	24hrs.min.

8. Birthplace.....Harford Co. Md.
(Town, county, and state)

10. Usual occupation..... **Farmer**

11. Industry or business _____

FATHER	12. Name.....	James Hall
	13. Birthplace.....	Harford Co. Md.

MOTHER	14. Maiden name	Unknown
	15. Birthplace	— — — — —

16. Informant.....Hattie P. Hall
Address.....Rocks, Md.

17. Burial Date thereof Mar. 27, 194
(Burial, cremation, or removal) Which? (month) (day) (year)
Cemetery or crematory Chestnut Grove cemetery
Location Rocks, Md.

18. Funeral director..... Hubert P. Harkins
Address..... Delta, Penna.

19. 3/26. 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....March 25.....1946.....at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1946 to March 25 1946 and that I last saw ~~him~~ her alive on March 23 1946.

Immediate cause of death	DURATION
Chr Myocardial Disease	3
Gen. Atherosclerosis	3
Due to	

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Willard P. Hudson
M, D, or other
Address Forest Hill Ind Date signed 3/26/48

MARGIN RESERVED FOR BINDING

VS. A15-

CERTIFICATE OF DEATH

RECEIVED
APR 2 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02711



Reg. Dist. No. 182

1. PLACE OF DEATH:

County Bel Air Md
 City or town Bel Air Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford
 City or town Bel Air Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Bel Air Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Thomas A

3. (b) Social Security Number

Heaps

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Paul Heaps
 6.(c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) Jan 24, 1894
 8. AGE: Years 52 Months 2 Days 4 If less than one day
 hrs. min.

9. Birthplace Harford Co Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Frank Heaps

13. Birthplace Harford Co Md

14. Maiden name Ella Jane Smiley

15. Birthplace Harford Co Md

16. Informant Mrs. Paul Heaps

Address Bel Air Md

17. Date thereof April 3, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Bel Air Md

18. Funeral director W. Woodruff

Address Farm Grove Rd

19. 3/31/46 Bel Air Md

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 at 130 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Fracture cervical vertebra

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

Due to

Other conditions

Due to

RECEIVED
APR 2 1945
BUREAU T.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

02712 182
Reg. Dist. No.

1. PLACE OF DEATH: Harford
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... md County..... Harford
City or town..... Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... no

3. (a) FULL NAME John Earl Heck

3. (b) Social Security Number no

4. Sex Male 5. Color or race White 6. Single, married, widowed, or divorced Widower

8. (b) Name of husband or wife Larrah Heck

7. Birth date of deceased (mo., day, yr.) Nov 29, 1893 8. (c) If alive, give age..... years

8. AGE: 52 Years 3 Months 18 Days If less than one day..... hrs. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Army

12. Name Philip Heck

13. Birthplace Harford Co., Md.

14. Maiden name Dennie Hazelton

15. Birthplace Harford Co., Md.

16. Informant Charles Burstein

Address Forest Hill Md.

17. Burial Date thereof March 20, 1946
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematorium Rock Spring Cem

Location Harford Co., Md.

18. Funeral director H. S. Bailey

Address Charlottesville, Md.

19. 3/18 46 Priscilla Lowwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 46 at 1:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death Fracture skull

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident 3/17/46
Accident, suicide, or homicide Date of.....
Where did injury occur? Rock Harford md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 29 Rock, md

Means of injury Auto accident Injured at work? no

David C Palmer MD

23. SIGNATURE Deputy Medical Examiner

Harford County M. D. or other

Address Bel Air, Md. Date signed 3/17/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 21 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE LIMITS 08

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1382

CERTIFICATE OF DEATH

02713

★ Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Pearl Crossell Henry

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Joseph G. Henry8. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) Feb. 2 - 1897

8. AGE: Years Months Days If less than one day

49118

hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Edward Crossell13. Birthplace Maryland14. Maiden name Annie Brown15. Birthplace Maryland16. Informant Joseph G. HenryAddress 552 Shiland, Harre de Grace17. Burial Date thereof 3/23/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. JamesLocation Harre de Grace18. Funeral director Presbyterian Bur.Address Harre de Grace19. March 21, 1946 G. L. Lewis M.D.

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 552 Shiland

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1946, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 20, 1946, to March 20, 1946and that I last saw him alive on March 20, 1946Immediate cause of death Cerebral hemorrhage

DURATION

1 dayDue to Arteriosclerosis 2 yrsDue to Chronic Interstitial Nephritis 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Albert M.D.

M. D. or other

Address Harre de Grace Date signed 3/24/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

FILE NO.

POSTAL ADDRESS

RECEIVED
MAR 25 1946
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

02714

Reg. Dist. No. 180

1. PLACE OF DEATH:

County Harford
 City or town near Poole's Island
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 305 E. 24th
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Janet T. Hoffmann

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb. 13, 1926

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

19

3

5

hrs.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Government Employee

11. Industry or business

FATHER

12. Name

Carl Hoffmann

13. Birthplace

Austria

14. Maiden name

Hermine Beckhne

15. Birthplace

Austria

16. Informant

Carl Hoffmann

Address

305 E 24th St, Balti Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Apr 1, 1946

Cemetery or crematory

Cathedral

Location

Baltimore Md

18. Funeral director

Wiedefeld & Son

Address

22nd at Greenmount Ave, Balti Md

19.

(Date rec'd by registrar)

19.

46

Marie M. Mouchette

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946 at 2P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Drowning, accidental

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 18, 1945Where did injury occur? Edgewood Harford Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Chesapeake BayMeans of injury Sail boat capsized Injured at work? noSignature Derald C Palmer M.D.23. SIGNATURE DEPUTY MEDICAL EXAMINERAddress BAL AIR Date signed 3/28/46

RECEIVED

APR 4 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 03115 181

1. PLACE OF DEATH:

County Harford

City or town R. D. #2 - Aberdeen, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town R. D. #2 - Aberdeen, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

JOSEPHINE HORKY

3. (b) Social Security Number

4. Sex female

5. Color or race white

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife xx Rudolph Horky

6(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 1, 1888

8. AGE: Years 57 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Kalal

13. Birthplace unknown

14. Maiden name "

15. Birthplace "

16. Informant Dr. J. Ralph Horky - son

Address Churchville, Maryland.

17. Burial Date thereof 3/26/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore, Md.

18. Funeral director Charles E. Schimunek

Address 2601-03 E. Madison Street

19. 3-25 19 46 Dr. J. Ralph Horky

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 19 46, at 19 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 29 19 46 to Mar 23 19 46

and that I last saw him alive on Mar 22 19 46.

Immediate cause of death Coronary Thrombosis

Due to Anteroseptal

Due to _____

Other conditions Chronic Endocarditis

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. J. Donnell M. D. or other _____

Address 104 W. Madison St. Date signed Mar 25, 1946

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19120

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford

City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Bel Air Ave. West
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 6, 18746. (c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

7157

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 13

19

at

4⁰² P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

19

and that I last saw him alive on

19

Immediate cause of death

Cardiac Failure

DURATION

Due to

Hypertensive cardio-vascular disease

Due to

Chronic nephritis

Other conditions

Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

James E. Macanby, M.D.Address 804 Giles St. Harford, Md.Date signed 2-14-46

RECEIVED

MAR 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02716

Reg. Dist. No.

181

1. PLACE OF DEATH:

County.....Harford
 City or town.....Aberdeen Proving Ground, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....Since 21 February 1946
 Hospital, institution, or street address where death occurred:
Station Hospital, Aberdeen Proving Ground, Md.
 How long in hospital or institution?.....Since 13 March 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....New Hampshire..... County.....
 City or town.....Alton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Norman Kelley

3. (b) Social Security Number

4. Sex.....Male
 5. Color or race.....White
 6. (a) Single, married, widowed, or divorced.....Single

6. (b) Name of husband or wife.....Single

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....September 13, 1908

8. AGE: Years.....17 Months.....17 Days.....6 If less than one day..... hrs. min.
10

9. Birthplace.....New Hampton, New Hampshire
(Town, county, and state)10. Usual occupation.....Soldier

11. Industry or business.....

FATHER
 12. Name.....
 13. Birthplace.....

MOTHER
 14. Maiden name.....Celia Hutchins
 15. Birthplace.....unknown

16. Informant.....Mrs. Celia Hutchins (mother)Address.....Alton, New Hampshire

17. Transportation Date thereof.....Mar. 25, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Windsor Funeral Home
 Location.....Laconia N.H.

18. Funeral director.....Howard H. Robinson
 Address.....Abingdon Maryland

19. March 1946 Nellie Kiley
 (Date rec'd by registrar) (Registrar)

I have received the remains of the above in good condition.

MEDICAL CERTIFICATION

20. DATE OF DEATH.....23 March 1946..... 19..... at.....0750..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
From 13-55 13 Mar. 1946 to 0750 23 Mar. 1946
 and that I last saw him alive on 0750 23 Mar 46 19.....

Immediate cause of death.....Scarlet Fever

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....James Zubrow
M. D. or otherAddress.....Station Hospital, Aberdeen Proving Ground, Md. Date signed.....23 March 1946

03710

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

RECEIVED
APR 2 1944
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County HarfordCity or town Rocks - Harford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Rocks, md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN FRANCIS LAGAN

3. (b) Social Security Number

4. Sex M5. Color or race wh

6.(a) Single, married, widowed, or divorced

wid.6.(b) Name of husband or wife Sarah Terry Lagan

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 1 - 18668. AGE: Years 79 Months 7 Days 16 If less than one day _____ hrs. _____ min.9. Birthplace Harford Co. - md
(Town, county, and state)10. Usual occupation Carpenter - retired

11. Industry or business

12. Name Andrew Lagan13. Birthplace Harford Co. md14. Maiden name Archie Mc Silligan15. Birthplace Ireland.16. Informant Mrs John E. EverettAddress Rocks md17. Burial Date thereof May 18, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St MarysLocation Pylesville18. Funeral director Martin H. KurtzAddress Garrettsville, Md.19. May 18 19. 46 Thomas P. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19. 46 at 12:15 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 19. 46 to March 15 19. 46and that I last saw him alive on March 14 19. 46Immediate cause of death Hypostatic pneumoniaterminatingDue to Cerebral Hemorrhage

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson

M. D. or other

Address Forest Hill mdDate signed 3/15/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 4 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

 02717-185-
 Reg. Dist. No.

1. PLACE OF DEATH County <u>Harford</u> City or town <u>Harre de Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>1 day</u> Hospital, institution, or street address where death occurred: <u>Harford Memorial Hospital</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Harford</u> City or town <u>New Aberdeen</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Gene Lee</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>unknown</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife				2D. DATE OF DEATH <u>March 20</u> 19 <u>46</u> <u>3:10 P</u> M			
7. Birth date of deceased (mo., day, yr.) <u>unknown</u>				2I. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____ and that I last saw him _____ alive on _____ 19____			
8. AGE: Years <u>about 55</u> Months <u>?</u> Days <u>?</u> It less than one day _____ hrs. _____ min.		6. (c) If alive, give age _____ years		Immediate cause of death <u>Bronchopneumonia</u>		DURATION <u>1 da.</u>	
8. Birthplace <u>North Carolina</u> (Town, county, and state)				Due to			
10. Usual occupation <u>laborer</u>				Due to			
11. Industry or business				Other condition <u>Arteriosclerotic</u> <u>C.V. disease</u> (Include pregnancy within 8 months of death)			
FATHER 12. Name <u>unknown</u>		13. Birthplace		Major findings of operations			
MOTHER 14. Maiden name		15. Birthplace		Date of op.			
16. Informant <u>Harb Records</u> Address <u>Harre de Grace</u>				Autopsy results			
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>3/22/46</u> (month) (day) (year) Cemetery or crematory <u>Angel Hill</u> Location <u>Harre de Grace</u> <u>Greenington & Son</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
18. Funeral director <u>Greenington & Son</u> Address <u>Harre de Grace</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
19. Mar. 21 19 <u>46</u> <u>W. L. Lewis M.D.</u> (Date rec'd by registrar) Registrar				23. SIGNATURE <u>Leard C Palmer M.D.</u> <u>Deputy Medical Examiner</u> <u>Harford County</u> Address <u>Belt Ave, Md.</u> Date signed <u>3/20/46</u>			

CERTIFICATE OF DEATH

RECEIVED
MAR 25 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

02718

★ Reg. Dist. No. 181

1. PLACE OF DEATH:

County Barford
 City or town Rural Sheridan
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Barford
 City or town Rural Sheridan
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Sheridan
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

John Franklin Leonard

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Larley Shinnault

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

May 20 1869

8. AGE: Years Months Days If less than one day

76 9 hrs. min.

9. Birthplace

Marion Va. Smith Co

10. Usual occupation

Farmer

11. Industry or business

12. Name

Franklin Leonard

13. Birthplace

Marion Va

14. Maiden name

Unknown

15. Birthplace

Virginia

16. Informant

Mr. Preston J. Leonard

Address

Sheridan Md. R.F.D. #1

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Burial March 17 1946

Cemetery or crematory

Smith Chapel

Location

Near Churchville Barford Co.

18. Funeral director

Harry Jazung & Sons

Address

Sheridan Md

19. (Date rec'd by registrar)

Mar 16 1946

Registra

Nellie J. Wiley

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1946 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13 1946 to March 14 1946

and that I last saw him alive on March 14 1946

Immediate cause of death

Pulmonary edema

Due to

Arteriosclerotic Cardiovascular Disease

Due to

Other conditions

Anemia

Chronic nephritis

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis C. Gareis M.D.

Address

Churchville MD

Date signed

3/15/46

MARGIN RESERVED FOR BINDING

VS A15 9-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02719

Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 131 S. Union Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rose M. Levy

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bernard Gott Levy

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Mar. 10, 1879

8. AGE:

Years

Months

Days

If less than one day

661126

hrs.

min.

9. Birthplace

Florence, S. C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Levis Manheim

13. Birthplace

S. C.

MOTHER

14. Maiden name

Caranda Rosenstein

15. Birthplace

S. C.

16. Informant

Mr. B. Levy

Address

Harre de Grace, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

3/10/46
(month) (day) (year)

Cemetery or crematory

Hebrew Friendship

Location

Baile, Md.

18. Funeral director

Hebrew Friendship

Address

Baile, Md.

19.

March 8, 1946

19.

A. L. Lewis, Jr.Harre de Grace, Md.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946, at 6 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 4 1942, to 3-8-46 1946and that last saw h. es. alive on 3-8-46 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Diabetes Mellitus

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Lewis, Jr.

M. D. or other

Address Harre de Grace, Md. Date signed 3-8-46

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

ADJUTANT GENERAL'S OFFICE

ADJUTANT GENERAL'S OFFICE

RECEIVED

MAR 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)Street No. 308 S. Union Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Melvin

3. (b) Social Security Number

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Ethel Lamm Melvin6.(c) If alive, give age 3 years7. Birth date of deceased (mo., day, yr.) Sept. 15/18708. AGE: Years 75 Months 5 Days 20 If less than one day9. Birthplace England
(Town, county, and state)10. Usual occupation Retired lumber Dealer

11. Industry or business

12. Name William J. Melvin13. Birthplace England14. Maiden name Ethel Willis15. Birthplace England16. Informant Mrs. Ethel J. MelvinAddress 308 S. Union Ave Harford Chase17. Burial Date thereof 3/11/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Harford Chase18. Funeral director Funerary CoAddress Harford Chase19. Mar. 10 19 46 A. L. Lewis, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 19 46 at 7:35 P. M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 38 to Mar 8 19 46and that I last saw him alive on Mar 8 19 46Immediate cause of death ArteriosclerosisDue to Arteriosclerosis DeformansDue to Arteriosclerosis DeformansDue to Arteriosclerosis DeformansOther conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley, M.D.Address Harford ChaseDate signed 3/10/46

U.S. DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH

RECEIVED

MAR 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

02721

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harde Chase
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford

City or town Harde Chase
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 519 S. Stokes
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Agnes Miller

3. (b) Social Security Number

4. Sex Female 5. Color of face Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife James Miller

6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) October ? 1899

8. AGE: Years 46 Months 4 Days ? It less than one day

hrs. min.

9. Birthplace Union S. Carolina
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Briggs

13. Birthplace Union S. Carolina

14. Maiden name Unknown

15. Birthplace

16. Informant Willie Hodge

Address 2312 N. Tawn St. Phila. Pa.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 3/10/46
 (month) (day) (year)

Cemetery or crematory St. James A. M. E.

Location Harde Chase

18. Funeral director Funerary Home

Address Harde Chase, Md.

19. Mar. 8 19 46 A. L. Lewis reg'd.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 46 at 6:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19 46 to March 6 19 46

and that I last saw him av. alive on Mar. 5 19 46

Immediate cause of death Cerebral insufficiency

Due to Lobar Pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Hodge M. D., or other

Address Harde Chase, Md. Date signed 3-8-46

CERTIFICATE OF DEATH

RECEIVED

MAR 11 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02722

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HartfordCity or town Fountain Green
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Davis Thomas
Infant Moxley

3. (b) Social Security Number

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

✓

6. (b) Name of husband or wife.

7. Birth date of

deceased (mo., day, yr.)

Mar 23 - 46

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6 hrs.55 min.

9. Birthplace

Fountain Green

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Otto Moxley

13. Birthplace

W. Va

14. Maiden name

Clara Geller

15. Birthplace

N. Y

16. Informant

Mr Otto Moxley

Address

Darlington17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 25/46
(month) (day) (year)

Cemetery or crematory

MT Zion

Location

Fountain Green

18. Funeral director

Deary & Inter

Address

Bel Air Md

19.

(Date rec'd by registrar)

3/2519. 46Priscilla Forward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

March 23 1946 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 23 - 1946 to Mar 23 1946and that I last saw her alive on March 23 1946

Immediate cause of death

Prematurity (6 mos)

DURATION

6 hr
55 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(Country)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address

Forest Hill MdDate signed 3/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF NATURALIZATION

RECEIVED
MAR 28 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02723

Reg. Dist. No. 182

1. PLACE OF DEATH:

County FrederickCity or town Bell Air
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days + 2 hrs. 50 minsHospital, institution, or street address where death occurred:
Fountain Green HospitalHow long in hospital or institution? 2 days + 2 hrs. 50 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Darlington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sue Maxey Moxley

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced _____B. (b) Name of husband or wife. ✓7. Birth date of deceased (mo., day, yr.) March 23, 1946 6. (c) If alive, give age _____ years8. AGE: Years _____ Months _____ Days 2 less than one day 2 hrs. 50 min.9. Birthplace Fountain Green
(Town, county, and state)10. Usual occupation. ✓

11. Industry or business

12. Name Otto Moxley13. Birthplace W. Va14. Maiden name Clara Greer15. Birthplace NY16. Informant Mr Otto MoxleyAddress Darlington17. Burial Date thereof Mar 25/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MT ZionLocation Fountain Green18. Funeral director Danny FosterAddress Bell Air Md19. 3/25-46 Phiscilla Louwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25-1946, at 3:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 19 46, to March 24 19 46
and that I last saw him alive on March 24 19 46Immediate cause of death prematurity (6 mos) DURATION 2 day
2 hrs
53 20.25

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson M. D. or other _____Address Forest Hill Md Date signed 3/25/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 28 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02724

Reg. Dist. No. 184

1. PLACE OF DEATH:

County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Wm. A. Norris

3. (b) Social Security Number

218-07-8795

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Emma Norris
 6. (c) If alive, give age 65 years
 7. Birth date of deceased (mo., day, yr.) Feb. 11, 1869

8. AGE: Years 77 Months 1 Days 10 If less than one day
hrs.min.

9. Birthplace Harford Co., Md.
(Town, county, and state)10. Usual occupation farmer11. Industry or business crop12. Name Unknown13. Birthplace Elizabeth Little14. Maiden name Harford Co., Md.15. Birthplace Mrs. Emma Norris16. Informant Harford Co., Md.Address Darlington Md.17. Burial Date thereof March 23, 1946
(Burial, cremation, or removal? (month) (day) (year))Cemetery or crematory Darlington Cem.Location Harford Co., Md.18. Funeral director H. S. BaileyAddress Darlington Md.

March 22, 1946 M. G. Hulse

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946 at 5:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1946 to March 21 1946and that I last saw him alive on March 21 1946

Immediate cause of death

acute myocarditis DURATION 21 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gallion M. D. or otherAddress Darlington, Md. Date signed 3-21-46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

RECEIVED

RECEIVED

MAR 28 1946

RECEIVED

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9320

CERTIFICATE OF DEATH

03116

Reg. Dist. No. 184

1. PLACE OF DEATH: Harford
County Harford
City or town Harlington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Harford
City or town Harlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION) ms

2(a) If veteran, name war _____

3. (a) FULL NAME Allen Presberry 3. (b) Social Security Number 213-14-3165

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Raisy Presberry

7. Birth date of deceased (mo., day, yr.) March 19, 1896 6. (c) If alive, give age _____ years

8. AGE: Years 50 Months 19 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Rachel Presberry

15. Birthplace Harford Co., Md.

16. Informant Mr. Edna Presberry

Address 18 Center St., Port Deposit, Md.

17. Burial Date thereof April 19, 1946
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematorium Holanna Cem.

Location Harford Co., Md.

18. Funeral director A. S. Bailey

Address Harlington, Md.

March 30, 46 M. G. Kirk

19. (Date rec'd by registrar) _____ Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1946, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 12 1946, to Mar 29 1946, and that I last saw him alive on Mar 12 1946.

Immediate cause of death myocarditis

Due to ✓

Due to ✓

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. P. Smith

M. D. or other _____

Address Harlington Date signed 3/29/46

CERTIFICATE OF DEATH

RECEIVED
APR 17 1946
BUREAU OF

RECEIVED BY BUREAU OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02725

Reg. Dist. No. 184

1. PLACE OF DEATH:

County HarfordCity or town Harlington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County HarfordCity or town Harlington
(If outside city or town limits, write RURAL and give nearest town)Street No. 97 W 19th
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry J. Presberry Jr.

3. (b) Social Security Number

4. Sex Male5. Color or race Negro6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Susan C. Presberry

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 24, 18758. AGE: Years 71 Months 8 Days 16 If less than one day hrs. min.9. Birthplace Castleton, Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Henry J. Presberry Sr.13. Birthplace Maryland14. Maiden name Kesgar Prigg15. Birthplace Maryland16. Informant Miss Alice PresberryAddress Harlington, Harford, Maryland17. Burial Burial Date thereof 3-16-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rosanna CemeteryLocation Harlington, Maryland18. Funeral director Elmer E. KellieAddress 536 Lewis St. Laure de Grace, Md

19. Mar. 16 1946 M. W. Kells Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1946 at 9:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-9-1945 to 3-12-1946and that I last saw him alive on 3-11-46

Immediate cause of death

DURATION

Coronary occlusion 3-11-46Due to Chronic myocarditis 6-9-45

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Claude L. Deewan M.D.Address Laure de Grace Date signed 3-16-46

RECEIVED
MAR 28 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17009

CERTIFICATE OF DEATH

02699

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Chesden
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Chesden
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Old Camp
 (If rural, give LOCATION)
 2.(a) If veteran, name war Korean

3. (a) FULL NAME

Walter B. Bemins

3. (b) Social Security Number

230-54-3745

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Julia Neal
 7. Birth date of deceased (mo., day, yr.) June 19, 1893
 8. AGE: Years 52 Months 8 Days 42 If less than one day 42 years
hrs.min.

9. Birthplace Tayall, Va.
(Town, county, and state)10. Usual occupation Day Labor

11. Industry or business

12. Name Chap. R. Bemins13. Birthplace Virginia14. Maiden name Lue Scott15. Birthplace Virginia18. Informant Julia R. BeminsAddress Chesden Md17. Burial Date thereof Mar. 9-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GraveLocation Chesden Md18. Funeral director Henry Tagging HouseAddress Chesden Md19. Mar. 8 19 46 Nellie H. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 46, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19....., to.....19.....
 and that I last saw h.....alive on.....19.....

Immediate cause of death Fracture skull
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 3/3/46
 Accident, suicide, or homicide Accident Date of 3/3/46
 Where did injury occur? Chesden Harford Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Y.S. Route 40
 Means of injury Hit by auto Injured at work? no
Dorothy C. Palmer M.D.
 23. SIGNATURE Deputy Medical Examiner
Harford County M. D. or other
 Address Bel Air, Md. Date signed 3/3/46

RECEIVED
APR 2 1946
BUREAU VER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS COUPON IS LIMITED TO ONE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH: *Harford*
 County.....
 City or town.....*Rural Harford Grace*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
R.D. #2
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*md.* County.....*Harford*
 City or town.....*Rural Harford Grace*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*R.D. #2*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Henry Galean Rincer*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Eva Mae Rincer*
 7. Birth date of deceased (mo., day, yr.) *Feb. 13, 1876* 6.(c) If alive, give age *67* years
 8. AGE: Years *70* Months *1* Days *8* If less than one day
 hrs. min.

9. Birthplace *Cecil G. Md.*
 (Town, county, and state)
 10. Usual occupation *Appraiser*
 11. Industry or business *Port of Balto*
 12. Name *John Rincer*
 13. Birthplace *Penn.*
 14. Maiden name *Mary Agnes Archibald*
 15. Birthplace *Md.*

16. Informant *Mrs. Eva M. Rincer*
 Address *Harford Grace Md. R.D. #2*
 17. Burial *Burial* Date thereof *Mar. 23, 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *West Nottingham*
 Location *Cecil G. Md.*
 18. Funeral director *R. Madison Mitchell*
 Address *Harford Grace Md.*
 19. *Mar. 22* 19 *46* *A. L. Lewis M.D.*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Mar. 21* 19 *46* at *5:30* A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar. 1* 19 *46* to *Mar. 21* 19 *46*
 and that I last saw him/her alive on *Mar. 20* 19 *46*
 Immediate cause of death *Carcinoma of Stomach*
 DURATION

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE *A. L. Lewis M.D.* M.D. or other
 Address *Harford Grace Md.* Date signed *3-22-46*

RECEIVED

MAR 25 1946

BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



02726

184

Reg. Dist. No.

1. PLACE OF DEATH:

County Harford

City or town Carsiff
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3.3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Carsiff
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Florence D. Robinson

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Harry Robinson

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov. 8 - 1893

8. AGE: Years 52 Months 4 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William B. Davis

13. Birthplace Harford Co. Md.

14. Maiden name Mary A. Harry

15. Birthplace Harford Co. Md.

16. Informant Harry Robinson

Address Carsiff, Md.

17. Burial Date thereof Mar. 25 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stateville cemetery

Location Delta, Pa.

18. Funeral director Hubert R. Harkness

Address Delta, Pa.

March 24, 46 M. G. Kirk

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946, at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to March 23, 1946

and that I last saw him/her alive on March 22 1946

Immediate cause of death Carcinoma of

uterus.

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

Due to _____

Due to _____

Other conditions _____

MAINE AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MAINE

MAINE AND STATE DEPARTMENT OF HEALTH

RECEIVED
MAR 28 1946
BUREAU

RECEIVED

MAR 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**
of deceased is shown on 2411 N. Charles St., Baltimore (800)

CERTIFICATE OF DEATH

★ 02729 181
Reg. Dist. No.

FILM No. I O 1 APR 11 1946

1. PLACE OF DEATH:

County Hartford
City or town Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years in Army
Hospital, institution, or street address where death occurred:
Aberdeen Proving Ground, Maryland.

How long in hospital or institution? 2 days

3. (a) FULL NAME

RUSCH, FRANK J.

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Helen A. Rusch

7. Birth date of deceased (mo., day, yr.) 8 January 1908 6. (c) If alive, give age years

8. AGE: Years 36 38 Months 2 Days 17 It less than one day hrs. min.

9. Birthplace Chicago, Ill.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name

15. Birthplace

16. Informant U.S. Army Records

Address Aberdeen Proving Ground Md

17. Transportation Date thereof Mar 26, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Adolph Hupke Funeral Home

Location 6759 Roswell St, Chicago Ill

18. Funeral director Howard K. McKenna & Son

Address Aberdeen Maryland

19. Mar. 26 19 46 Nellie A. Wiley
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Hartford

City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No. Baldwin Manor. Unit C 64
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 March 19 46 at 1009 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 March 19 46 to 25 March 19 46

and that I last saw him alive on 25 March 19 46

Immediate cause of death Abscess, right side, brain, acute, cause undetermined.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results (See reverse side)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. K. Nichols

F. K. NICHOLS, Lt Col, MC M. D. or other

Address Sta Hosp. APG, Md Date signed 25 Mar/

I certify I have received the remains of the above in good condition.

AUTOPSY RESULTS:

- No. 1. Otitis media, chronic, suppurative, right middle ear.
Cause undetermined.
- No. 2. Petrositis, right temporal bone.
- No. 3. Abscess, temporal lobe, right lower portion. Encapsulitis.
- No. 4. Herniation, cerebellum, through foramen magnum with
internal hydrocephalus.
- No. 5. Meningitis, acute, diffuse of cerebral and cerebellar
lobes and brain stem.
- No. 6. Pulmonary edema, acute.



CENTRAL FILE OF DEATH

RECEIVED BY THE DEPARTMENT OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 125

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 67 yrs.

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)Street No. 574 Revolution

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Emma Skinner Summons

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Wm. F. Summons7. Birth date of deceased (mo., day, yr.) July 16, 18788. (c) If alive, give age 75 years8. AGE: Years 67 Months 8 Days 4 If less than one day

hrs. min.

9. Birthplace Harford

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Skinner13. Birthplace Maryland14. Maiden name Francis Skinner15. Birthplace Maryland16. Informant Wm. F. SummonsAddress 574 Revolution, Harford17. Burial Date thereof 3/28/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. JamesLocation Harford19. Funeral director Summons & SonAddress Harford19. 3-25 19 46 A. L. Lewis M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 19 46 at 4:50 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6 19 45 to Mar 21 19 46and that I last saw him alive on Mar 21 19 46

Immediate cause of death

Acute CoronaryThrombotic CoronaryDue to arteriosclerosisEssential

Due to

Other conditions Toxemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.Address Harford Date signed 3/27/46

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

DATE OF BIRTH

DECEASED

DIAGNOSIS

RECEIVED

MAR 27 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02731

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
City or town Falton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Wife
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ann Takanev

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife John Takanev7. Birth date of deceased (mo., day, yr.) Sept. 11, 1864 6.(c) If alive, give age years8. AGE: Years 81 Months Days If less than one day hrs. min.9. Birthplace Ind.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Putrick Mc Gilligan13. Birthplace Ireland14. Maiden name Margaret Wagan15. Birthplace Ireland16. Informant Miss Mary TakanevAddress Falton Md.17. Burial Date thereof 3/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Long GreenLocation St Johns18. Funeral director Harbinger BrosAddress Baltimore, Md.19. 3/15 19 46 Priscilla Townsend
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 3/13 19 46 at M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19 33 to Mar 13 19 46and that I last saw h. or alive on Mar 13 19 46
Immediate cause of death Intestinal obstruction DURATIONPostoperativelyDue to Adhesions following op.
several yrs ago.

Due to

Other conditions Chronic Myocarditis duration nine years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Perkins M. D. or otherAddress Bel Air Md Date signed 3/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 19 1946
BUREAU V.S.

19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02732

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days It less than one day
 hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name
 13. Birthplace
 14. Maiden name
 15. Birthplace

16. Informant
 Address

17. Burial, cremation, or removal. Which? Date thereof (month) (day) (year)

Cemetery or crematory
 Location

18. Funeral director
 Address

19. Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 17, 1946, to March 18, 1946

and that I last saw him alive on March 18, 1946

Immediate cause of death: Syphilis (?)

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.

Address Fork Md. Date signed 3/18/46

RECEIVED

MAR 21 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

Reg. Dist. No. 180

02733

1. PLACE OF DEATH:

County HarfordCity or town Belcamp
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. W. Lombard St. (644)
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Kasmier Vergel

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Maurie Vergel

7. Birth date of deceased (mo., day, yr.)

Jan 15 1884

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

62

.....hrs.min.

9. Birthplace

Lithuania

(Town, county, and state)

10. Usual occupation

Tailor

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

unknown

15. Birthplace

16. Informant

Charles Vergel

Address

644 W. Lombard St., Balt Md

17. Burial

(Burial, cremation, or removal Which?)

Date thereof

Mar 27, 1946
(month) (day) (year)

Cemetery or crematory

Holy Redeemers

Location

Bel Air, P.O. Box, Balt Md

18. Funeral director

Howard K. McGrawson

Address

Abingdon Maryland

19. Mar 23

(Date rec'd by registrar)

19. 46

Maurie M. Mowbray

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2346 at 10⁴³ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

Fracture cervical vertebra

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Accident Date of 3/23/46Where did injury occur? Belcamp Harford Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) P.O. R.R. tracksMeans of injury Tram Injured at work? no

23. SIGNATURE

Gerald C. Palmer M.D.
Deputy Medical Examiner

M. D. or other

Address

Bel Air, MdDate signed 3/23/46

RECEIVED

1946

RECEIVED

RECEIVED

MAR 28 1946

BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH

County Harford
City or town Joppa Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Harford
City or town Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No. Philadelphia Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Oscar Wainwright

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lillian Wainwright

7. Birth date of deceased (mo., day, yr.) May 5, 1900 6. (c) If alive, give age 46 years

8. AGE: Years 45 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Neward Ohio
(Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business Trucks Co.

12. Name Robert Wainwright

13. Birthplace Eastern Shore Md.

14. Maiden name Jannet

15. Birthplace Ohio

16. Informant Lillian Wainwright

Address Joppa Md.

17. Burial, cremation, or removal (which?) Burial Date thereof March 30, 1946
(month) (day) (year)

Cemetery or crematory W.F. Calverton

Location Mrs. Kate R. Williams

18. Funeral director Mrs. Kate R. Williams

Address 322 N. Schroeder St.

19. 3/27 1946 Registrar [Signature]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1946 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1946 to March 26 1946 and that I last saw him alive on 3-26 1946

Immediate cause of death Coronary Occlusion DURATION 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Red O. Hodous M. D. or other

Address Edgewood Md. Date signed 3-26-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

Reg. Dist. No. 02735 180

1. PLACE OF DEATH: Harford
 County Abingdon
 City or town Abingdon
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Abingdon
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William A. Warren

3. (b) Social Security Number

220-01-5776

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 23 1875 6. (c) If alive, give age 46 years

8. AGE: Years 71 Months — Days 24 If less than one day — hrs. — min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Franklin Warren

13. Birthplace

14. Maiden name Marguerite Morris15. Birthplace Baltimore Md16. Informant Wm. Kelley HarwoodAddress Abingdon Md

17. Burial Date thereof Mar. 30 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CockeysburgLocation Abingdon Md18. Funeral director Howard K. McGonigleAddress Abingdon Maryland

19. March 19 1946 Marie M. Wooddale
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1941 to March 1946
 and that I last saw him alive on March 14 1946

Immediate cause of death

Cornary Thrombosis

Due to

Arterio-sclerotic C.V. Disease

Due to

Other conditions

(Including pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Ralph Horky
Churchville Md
 Address Date signed March 17

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

RECEIVED

MAR 26 1944

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

Reg. Dist. No. 0273982

1. PLACE OF DEATH:

County Nassford
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution? County Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Nassford
City or town M. Fallsboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

FRITZ WELLS

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 9. 1856

8. AGE: Years 89 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace River Head - N. Y.
(Town, county, and state)

10. Usual occupation None

11. Industry or business _____

12. Name Wm. Wells

13. Birthplace New York

14. Maiden name Mary Hallbrook

15. Birthplace New York

16. Informant Delark Fitzpatrick

Address Bethesda MD

17. Burial Date thereof 3/30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory County Home

Location Bethesda MD

18. Funeral director Dean & Foster

Address Bethesda MD

19. 3/30/46 19 Priscilla Toward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 46 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 43 to Mar 30 19 46 and that I last saw him alive on Mar 20 19 46

Immediate cause of death CARCINOMA OF FACE DURATION 6 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wellard P. Hederson M. D. or other _____

Address Forest Hill Md Date signed 3/30/46

MARGIN RESERVED FOR BINDING

VS A15 9-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

031P

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HarfordCity or town Hallston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Johanna H. Whaland

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Hallston
(If outside city or town limits, write RURAL and give nearest town)Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James T. Whaland7. Birth date of deceased (mo., day, yr.) December 11th 1860 6. (c) If alive, give age years8. AGE: Years 85 Months 3 Days 15 If less than one day X X X min.9. Birthplace Baltimore Maryland
(Town, county, and state)10. Usual occupation at Home11. Industry or business 12. Name Maurice Hartigan13. Birthplace Ireland14. Maiden name Julia Olyubud15. Birthplace Ireland16. Informant Mrs. Anne H. ShipleyAddress Bel Air Md17. Burial Date thereof 3/28/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. IgnaceLocation Hickory, Harford Co. Maryland18. Funeral director George J. Ruth IncAddress 1735 Harford Ave19. 3/27 19. 46 C. J. Ruth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26th 19. 46 at 7:45 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 19. 46 to March 26 19. 46and that I last saw her alive on March 26 19. 46Immediate cause of death Pulmonary Decubus DURATION Due to CEREBRAL ARTERIO-SCLEROSIS and PsychosisDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE W. Millard Hiskins M.D. M. D. or other Address Hallston Md Date signed 3/26/46